NATUROPATHIC PEDIATRIC INTAKE FORM

MICHELLE CHIN, DOCTOR OF NATUROPATHIC MEDICINE
3000 HWY 7 EAST SUITE 205 MARKHAM ONTARIO L3R 6E1
PHONE 905.305.6033 FAX 905.305.0063 WWW.ADVANCEDHEALTHRECOVERY.CA

GENERAL

Name:				Date of 1st Visit:
Date of Birth: dd /mm /yyyy	Age:	Gender:	Height:	Weight:
Address:				
City:		Prov:	Postal Code:	
Phone (home):		Phone (work):		
Phone (cell):		Email:		
Person completing this form:				
Name of Guardian:			Relationship:	
Name of Guardian:			Relationship:	
With whom does this child live?				
Was this child adopted?	If yes, at what age?			

EMERGENCY CONTACT

Name:	Relationship:
Phone (home):	(work/cell):

OTHER HEALTH CARE PROVIDERS

1.	2.
Phone:	Phone:
Fax:	Fax:
3.	4.
Phone:	Phone:
Fax:	Fax:

Please indicate any regular screening tests your child has done:
____

Date of last screening test or physical exam:

____

How did you hear about our clinic?

____

HEALTH HISTORY

Reason for visit (list in order of importance):	**How long has the child had this condition?**

What type of therapies have you tried in the past for these concern(s)?

q Diet Modification q Vitamins/minerals q Herbs q Homeopathy q Chiropractic q Pharmaceuticals
q Other ____

What was the outcome?

____

Please list all prescriptions, over the counter medications, supplements, vitamins or natural health products the child is **currently** taking, the reason why, and for how long they have been taking them:

Medication/Natural Health Product	Reason Taking	How long

How many times has the child been treated with antibiotics?

____

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year	Illness, Surgery, Injury, Major Medical Diagnosis

_ _

Please list all allergies: (food, environmental, medications, etc)

____

____

Please list any food sensitivities:

____

____

Please list any other foods that are excluded from the child's diet and why:

____

____

Please check all of the following conditions that your child is currently experiencing (C) or has experienced in the past (P)

Condition	C P	Condition	C P	Condition	C P
Measles	q q	Mononucleosis	q q	Bed Wetting	q q
Chicken Pox	q q	Strep Throat	q q	Anxiety	q q
Headaches	q q	Rubella	q q	Asthma	q q
Mumps	q q	Chronic Runny Nose	q q	ADD/ADHD	q q
Ear Infections	q q	Hives/Rashes/Eczema	q q	Cold Sores	q q
Pneumonia	q q	Temper tantrums	q q	Sinus Problems	q q
Constipation	q q	Coughing/wheezing	q q	Seizures	q q
Scarlet Fever	q q	Colic/gas/cramping	q q	Diarrhea	q q
Tonsillitis	q q	Digestive Difficulties	q q	Frequent Colds	q q

VACCINATION HISTORY

Please indicate which vaccinations the child has received and the dates received

- q Diptheria dates _____________
- q Pertussis dates _____________
- q Tetanus dates _____________
- q Polio dates _____________
- q HiB dates _____________
- q Measles dates _____________
- q Other dates _____________
- q Mumps dates ____________
- q Rubella dates ____________
- q Hepatitis A dates ____________
- q Hepatitis B dates ____________
- q Chicken Pox dates ____________
- q Flu dates ____________

Please indicate if your child experienced any reaction or illnesses following a vaccination. Please indicate what the reaction was and to which vaccination(s)

____

____

____

FAMILY HISTORY

Please check any the following that a family member has experienced:

q Arthritis	q Diabetes	q Psoriasis
q Asthma	q Eczema	q Kidney Disease
q Alzheimer's Disease	q Drug Addiction/Alcoholism	q Stroke
q Autoimmune (MS, Lupus, etc)	q Heart disease	q Thyroid Issues
q Cancer	q High Blood Pressure	q Mental Illness
q Depression	q Migraine headaches	q Other ________________

PRENATAL HISTORY

Maternal age for the pregnancy: Paternal age for the pregnancy:
Number of previous pregnancies: Miscarriages: Abortions:

Please describe any problems with conception or infertility treatment received for this child:
____
____
____

Please check any of the following that applied to the pregnancy:

q Diabetes	q High Blood Pressure
q Nausea/vomiting	q Thyroid conditions
q Cigarette smoking	q Strep B positive
q Alcohol/tobacco/drug use	

____
q Bleeding ____
q Infections ____
q Prescription medication
____
q Supplements
____
q Over the Counter medications
____
q Prenatal testing
____
q Physical/Emotional trauma
____
q Workplace chemicals
____
q Exposure to disease or other harmful substances
____
q Other ____

Please indicate the general health/well-being of the parents during the pregnancy:

Mother:	q excellent	q good	qfair	qpoor	qunknown
Father:	q excellent	q good	qfair	qpoor	q unknown

Please indicate the general emotional well being of the parents during the pregnancy:

Mother:	q excellent	q good	qfair	qpoor	qunknown

Father: q excellent q good qfair qpoor q unknown

How was the mother's diet during pregnancy?
q excellent q good qfair qpoor qunknown

EARLY CHILDHOOD HISTORY

Where was the birth? ____

Name of obstetrician/midwife/health care providers: ____________________________

Gestational Age at Birth:

Preterm (< 37 wks) ____wks Term (38-42 wks) ____wks Post term (> 42 wks) ___wks

Birth Weight: _______ Length: _______ Head Circumference: __________

Please indicate if any of the following interventions were applied:

qInduction q Forceps q Vacuum extraction q C-section
qEpisiotomy q Pitocin q Pain medication q Epidural
qAntibiotics q Other ____

Were there any birth complications? (ie breech) ______________________________

How long was the labour? _________ APGAR Score (0-10) 1min: ___ 5min ____

Please indicate if any of the following were present shortly after birth:
q Infections/Fever q Respiratory Distress q Jaundice q Poor feeding q Anemia

q Congenital Defects q Colic q Rashes q Seizures q Birth Trauma/Injuries q Other: ___________________

DEVELOPMENTAL AND SOCIAL HISTORY

At what age did your child first:
Sit up ______ Crawl ______ Walk ______ Talk ______

At what age did your child begin teething? ______

Were there any difficulties associated with teething?
____

Is your child in: qschool qdaycare qhomecare qother What grade level? ______

General school/daycare behaviour/performance:____
____

How is the child's behaviour at home?

____

Does your child have any habits? ________________________ Any fears? _________________________________

Has the child been diagnosed with any learning disabilities? ____

Does your child make friends easily? ____

Child's interests and favourite activities: ____

According to your child, do they enjoy these activities? ____

How many hours/week does your child: Play on the computer or video games? ________ Exercise? ______
Watch television? ______ Read?(not for school) ______

Please write a little about your child's personality? ____
____

LIFESTYLE HABITS

What time does your child usually go to bed? _______ Wake up? _____________

Does your child nap during the day? Y / N What time(s): _____________________

Does your child have nightmares? Y / N How often? _______________________

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc)

____

Was the child breastfed? _____________________ For how long? _______________

Was the child formula fed? ____________________ Which formula? ______________

Please note any problems with or reactions to feeding: ____
____
____

When was solid food introduced? ____

Order of food introduction: ____

____

Please describe your child's eating behaviours (eg. Good appetite, picky eater, etc.)
____

Does your child have any strong food cravings or aversions?
____

Is the child exposed to any of the following on a regular basis?

qtobacco smoke q pets q old building q renovations qchemical fumes qnew building

Please describe:

____

What is the source of your child's drinking water?
q tap q filtered q distilled q bottled q other ________________

Marital status of the child's parents: q Married q Divorced q Separated

How would you describe the emotional climate of the child's home?
____
____